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I Am Surrounded by Love: an inquiry into the use of songs with a woman with traumatic brain injury, 11 years post-injury

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This research was completed as part of the degree requirements for the [Music Therapy](#) Department at Molloy College.

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I AM SURROUNDED BY LOVE: AN INQUIRY INTO THE USE OF SONGS WITH A
WOMAN WITH TRAUMATIC BRAIN INJURY, 11 YEARS POST-INJURY

Submitted in partial fulfillment of the requirements
For the degree of Master of Science
In Music Therapy

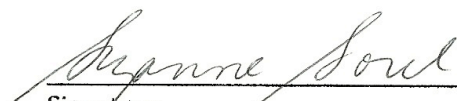
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I Am Surrounded by Love: An Inquiry into the Use of Songs with a Woman
with Traumatic Brain Injury, 11 Years Post-Injury

Abstract

The use of songs in music therapy with persons with traumatic brain injury (TBI) has many facets and applications in rehabilitation. Analyses of lyrics, song construct, and song choice have been examined with persons with TBI in coma states and early post-coma recovery, but more research is needed that focuses on what occurs when songs in therapy are introduced at a later point in TBI recovery. This narrative inquiry examined the therapeutic relevance of melody, rhythm, and song structure in songs for a woman with TBI from a 3-year period of weekly music therapy sessions. The participants in this study included the music therapy client (a woman with TBI in her mid-30s receiving music therapy for the first time 11 years post-injury), her art therapist, her primary care aide, and her mother. All participants were chosen by purposive sampling. Detailed therapist notes, recordings of therapy sessions, and interview dialogue provide the data for the study. Song lyrics and musical constructs were examined using detailed transcriptions of songs used in therapy. Results of this study may be used to inform music therapists on the effect of songs used in therapy with persons with TBI when music therapy is introduced a number of years after the injury.

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I would not be at this place in my life if not for the musical gifts passed on by my parents. The home that was forever filled with music from morning until the wee hours of the next

morning is a part of my being. I understand today that the many hours and weeks and years of practicing were to make me ready for this life—this calling--as a music therapist. I thank you both for your love and your support, and for not letting me quit my music lessons. I know I chose you to help me fulfill my destiny.

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INTRODUCTION

A gentle strum from the therapist's guitar creates an invitation with a single chord in E minor. "What is our opening song?" asks the therapist. The client, hesitating only a moment and grinning broadly in recognition as she begins, moves her left arm to indicate movement and direction as she sings the Navaho prayer chant. Her therapist is providing musical support with vocals and guitar chords. The client utters the lyrics in perfect rhythmic phrasing as the fingers on her raised hand wiggle to imitate a person walking:

"I walk in beauty..."

Beginning on the tonic, E4, the chant descends in a minor second and then down to the dominant or fifth, landing on the octave below the starting E.

Still smiling at her achievement of remembering our current opening song, she raises her right arm forward in front of her body and points to me:

"Beauty is before me..."

Now the melody returns to the original tonic, and rises with a major second leading to the perfect fourth, returning again to the tonic.

As she sings the next lines, her hand and arm move up and back behind her head, then up and finally pointing down toward the floor:

"Beauty is behind me, above and below me..."

The fifth above the tonic begins this phrase, descending to the tonic, rising briefly to touch the major third, back to the tonic and the fifth below, and coming to rest on the tonic as the vibrations from the guitar strings fade into a moment of silence.

Her hands return to her lap and she laughingly calls out the mnemonic device she developed and uses each week to help her remember my name: “You are my Pretty Cool music therapist, Pam Carlton.”

This musical communication occurred after a year of weekly music therapy treatment with a woman in her early 30s with traumatic brain injury (TBI), and who was challenged with severe deficits in short-term memory acquisition and recall. A clinically notable session, it was the first time she had independently recalled the opening song in her therapy sessions, singing the lyrics correctly and spontaneously without gestures, lyric hints, or additional musical prompting from the therapist. The therapist provided accompaniment on voice and guitar to provide melodic direction and support (Baker, Wigram, & Gold, 2005).

Throughout the course of therapy the music therapist introduced many pre-composed songs, and some improvised songs were created collaboratively during 3 years of therapy sessions. Both pre-composed and new songs became part of an ongoing therapeutic goal to acquire and maintain new memory through the repetition of song lyrics that appealed to the client’s preferences (Baker & Tamplin, 2006). The client is referred to as Danielle¹ throughout this writing, and I hold the dual roles of therapist who worked with her as well as the researcher in this study. At the time of this writing, I continue to work with Danielle once a week in hour-long sessions.

In my research capacity for this study I examined the songs utilized in Danielle’s therapy over a 3-year period. Pre-composed chants, folk and popular songs, and songs improvised within the course of treatment of weekly hour-long sessions comprised the body of musical work

¹ Pseudonym

with Danielle and are the primary sources of data to be examined in this case study. Songs from Danielle's pre-injury past and improvised songwriting were implemented in her music therapy sessions as a means of introducing and maintaining new memory through the creation of lyrics that had meaning for her (Magee, 1999).

The main question guiding my research was:

What occurs when songs are used with a woman with traumatic brain injury when music therapy is introduced 11 years post-injury?

Related questions include:

1. What was the relevance of melody, rhythm, and song structure?
2. What was the role of music in helping to reestablish Danielle's identity and sense of self?
3. How did songs encourage Danielle to sing, even as she continued to protest the sound of her voice?
4. What was the role of the music therapist in creating songs with the client?

Over the 3 years of weekly music therapy sessions with Danielle, most of which centered around the use of song re-creation and songwriting, she had what her therapy team considered startling memory gains through learning new lyrics and melodies, eventually singing them with me with little or no prompting at times.

This qualitative research is presented in a narrative case study format. D. Aldridge (2005) proposed utilizing a pluralist approach in research, to ensure that no single music therapy understanding "dominates the discussion" (p. 16). Creating meaning from experience, as occurs in the telling of stories, necessitates and validates the "strength of case study research" (p. 15). Creswell (2007) wrote that sometimes it is enough to just have a story to tell. G. Aldridge (2005)

concurr: “Stories have plots, characters, meaning and events. So too with music therapy sessions; there is a plot, therapist and patients, meaning and musical exchanges” (p. 47). Writing about a “key event” in a subject’s life—in this case, Danielle’s accident—and working from that event outward to past and subsequent events, will prove especially useful in this case study (Creswell, 2007, p. 186). Because of Danielle’s unique recovery path that includes therapy sessions provided in the patient’s family home, the use of re-creative and improvisational song methods, and the many cognitive and musical goals achieved at this later stage of recovery, her story has the potential of influencing the work of other music therapists and practitioners of related therapies in the TBI rehabilitation field.

MEETING DANIELLE AND BEGINNING MUSIC THERAPY

As a music therapy intern in 2002-2003, I was introduced to the traumatic brain injury (TBI) field working with adult outpatients in a music therapy group 1 hour each week for a year and a half. These sessions piqued my interest in the use of songs and improvised music with this population, but my music therapy jobs over the next few years led me to other areas of practice. After working primarily as a music therapist in the areas of psychiatry and pediatric medicine, I found myself facing a return to the field of music therapy with TBI.

At 21, Danielle had experienced a severe traumatic brain injury as the result of having been struck by a car while waiting at a bus stop on her Midwestern college campus toward the end of the year of her planned graduation. She spent months residing primarily in an intensive care unit in an inner-city hospital over 800 miles from home. Still comatose approximately five months after her accident, she was flown to a New Jersey rehabilitation facility to continue her medical care while beginning early intervention rehabilitation activity. Danielle survived many months of life-threatening complications and defied negative medical predictions when she

emerged from unconsciousness after 8 months. Eventually she was brought home to live with her parents in a suburb of New York City, the town in which she grew up.

Danielle was referred to me for music therapy for the first time by the art therapist on Danielle's therapy team 11 years after the accident, and I was subsequently hired to work with her in her family home where she resides. She had not received any music therapy up until this point. It was thought that music therapy would be an excellent addition to the therapy team, helping with the speech, memory, and fine motor goals already in place for Danielle and possibly providing a creative outlet for some new feelings that were emerging. Danielle's mother, Carolyn, later expressed her reluctance to incorporate music therapy earlier in her daughter's recovery, stating her belief that:

As people emerge...from the vegetative state they cannot have a lot of distraction...a lot of noise. They get very worked up, so I think that's a good part of the reason we cut back on the music...because she needed more quiet and the music was too stimulating (personal communication, February 2, 2012).

When I first met Danielle, she was sitting in a wheelchair, smiling and social. Almost immediately after our first greetings, she laughingly said that, although she was curious about music therapy, she felt the need to warn me that she "can't sing." She added that her family had teased her since she was a little girl about her "terrible" singing voice. Although fearful of being judged for her singing voice, Danielle quickly expressed her preference for the use of songs in therapy sessions, citing a love of music throughout her life.

She was initially unable to recall my name for any length of time during the first few months of hour-long sessions and had no memory of any of the songs we had sung a few minutes previously. The initial neurological forecast after she emerged from an 8-month coma was

devoid of hope, and the family was informed they should not expect much improvement in Danielle's overall abilities. However, with many therapists from a variety of disciplines working on common cognitive and physical goals, Danielle's recovery mimicked the phoenix rising up from the ashes to voice its beautiful song, and she was able to function in many ways that no one could have expected given the initial predictions from medical team. Her short-term memory deficits presented an ongoing challenge for her, but one that began to show marked improvement as the work in her music therapy sessions progressed.

As my assessment with her continued during our initial sessions, I discovered that she had a tremendous interest in a variety of pre-composed songs, and that she could remember lyrics from her teens and college years. Even though she frequently reminded me that no one in her life had ever complimented her on her singing, she continued to show great enthusiasm for the songs we sang. I wanted to explore the possibility of addressing Danielle's memory, speech and motor goals by utilizing songs that held meaning for her (Baker & Tamplin, 2006).

I initially introduced handheld percussion instruments, piano, and keyboard to Danielle's music therapy sessions to help with her fine motor goals (Baker & Tamplin, 2006), but she was usually more interested in singing songs with lyrics recalled from her largely intact long-term memory. Her frustration when attempting to focus on smaller movements was high, and her intention tremors would increase concurrently with her reported feelings of stress and pressure that she felt she had to perform (Magee, 1999). At this early stage, Danielle referred to our piano improvisations as "piano lessons." She did not enjoy therapy when she couldn't control her finger movements on the piano keys or with the small percussion instruments, and referred with apologies to a time when she was able to play simple pieces on the piano. It was important for the continuation of our work that she attain a "more 'able'" identity in our sessions, and it

seemed that singing was the more satisfying activity for her (Magee, 1999, p. 208). Our initial goals would center primarily on her cognition and memory improvements as well as continuing to help her discover her post-injury identity in the creation of music in therapy (Magee, 1999).

After a few sessions I brought a kazoo for each of us to use in a form of song re-creation and musical conversation that was intended to improve her breath support for singing and speaking (Baker & Tamplin, 2006). The kazoo also created more sound variety in our sessions, to counteract Danielle's initial impaired attention by keeping her more engaged in the music (Baker & Tamplin, 2006, p. 105). Her playfulness and humor emerged while humming improvisational rhythms and melodies into the kazoo, and we used it in many ensuing sessions as our warm-up after the greeting song to interact with each other in sound. Providing an opportunity for improvised music without lyrics created a "dynamic sense of interaction," and we often started our sessions by checking in musically on the kazoo (Magee, 1999, p.207).

Initial song choices were presented to Danielle from a wide array of songs she said she listened to in high school and college. "Because of the associations held with songs to events, people and places throughout an individual's life, songs represented old friends who had seen through good and bad times alike" (Magee, 1999, p. 209). It was possible the songs brought back memories of friends who were no longer able to stay in touch with Danielle for many reasons, but with whom she missed having contact, as she frequently mentioned names of girls and old boyfriends she used to know. I initiated pre-composed song possibilities in all sessions with her musical preferences in mind, as she needed assistance with recalling song titles. Our improvised songs were created together, and whereas Danielle needed to rely on my suggestions for melody, tempo, key, intervals, and meter, she created the words spontaneously with some minimal redirection to reduce her perseveration with words and repetition of ideas (Turry, 2006).

The singing of pre-composed songs from Danielle's past along with new songs introduced by the music therapist and those created together was a catalyst in increasing her ability to learn and remember not only the song lyrics, but also the rhythmic phrasings or prosody of the stanzas within the song melodies. Magee wrote that "implicit personal meanings and emotions" are embedded in clients' song choices, allowing opportunities for the therapist to provide support in a client's self-discovery process (p. 210). Danielle was revealing herself to me and perhaps finding parts of herself again by sharing her story one song at a time.

SONGS

But in the beginning there were no words; and at this time everything sang. The stones and the river, the trees and the moon, the bear and the eagle—all these sang their serenade.... and the soul of a thing was expressed through its song....[W]e had to use our voice and body to express the fundamental essence of things....Yet in the Western world, the act of singing has been sequestered by the fortunate elite who take lessons, learn scales and convince us that singing is a specialized art performed by the anointed. In fact, singing is a social and spiritual communion in which every man and woman, boy and girl has the right to take part. (Newham, 1999, pp. 4-5)

Merriam-Webster's (2011) online dictionary defines "song" as "the act or art of singing," "poetical composition," "a short musical composition of words and music," "a melody for a lyric poem or ballad," and "a distinctive or characteristic sound or series of sounds." These descriptions of songs are paralleled in the four main methods of music therapy as found in Bruscia (1998). Re-creative music therapy methods engage clients in replicating already-composed music; improvisational methods engage clients in extemporaneous music-making using instruments, voice, and body; the process of creating original melodies and lyrics falls into

the category of compositional music therapy; and utilizing music for client music listening is described as using a receptive methodology (Bruscia). In therapy sessions with Danielle, I utilized a variety of these song strategies while working toward her goals. Baker and Wigram (2007) referred to song as “both as an object, and as a form of musical expression” (p. 13), a concept mirrored in our singing of familiar songs, creation of new songs, and the singing of them together. Re-creative song techniques, where pre-composed musical pieces were implemented through singing and instrumental play, appealed to Danielle. She had been an avid music listener before her injury and had amassed a large and varied assortment of tapes and compact discs (CDs). All song topic areas were ones in which she was interested before her accident and which had stimulated many past memories for Danielle and ensuing conversations with me about her life before her injury.

Songwriting in music therapy is an unfolding process and “reflects the journey” toward a new understanding of a client’s reality (Tamplin, 2006, p. 177). Improvised songwriting was implemented in Danielle’s music therapy sessions in part as a means of introducing and maintaining new memory through the creation of lyrics that held meaning for her. Songwriting may have also served as an outlet for some of her thoughts and feelings. Quoting an Eskimo shaman, Orpingalik, in *Song and Silence*, Susan Elizabeth Hale (1995) wrote, “‘songs are thoughts, sung with the breath when people are moved by great forces, and ordinary speech no longer suffices’” (p. 32). It was possible that there were thoughts and feelings Danielle had not accessed since her injury that might be unearthed through revisiting songs and music from her pre-injury life, and that songs could help her find a way to express what she had been unable to speak in words.

REVIEWING THE LITERATURE

The literature I have reviewed encompasses studies addressing the use of songs in music therapy with traumatic brain injured clients, with a majority of the studies focusing on early recovery interventions. Topical areas pertinent to this research study include: music therapy with TBI, music therapy with TBI post-injury, songs in TBI, lyric analysis, and analysis of musical form.

Music Therapy with TBI

Many studies were found on this topic that mentioned the use of singing and songs in music therapy, focusing on improvements in goal areas of speech, mood, cognitive functioning, and motor functioning, with an overall goal of increased independence and community reintegration (Baker & Wigram, 2004; Baker, Wigram, & Gold, 2005; Magee & Davidson, 2002; Magee, Brumfitt, Freeman, & Davidson, 2006; Nayak, Wheeler, Shiflett, & Agostinelli, 2000; Tamplin, 2008; Tamplin & Grocke, 2008). While the use of songs has been described in these studies as part of the treatment protocol, the writings have mainly concentrated on the clinical goals, not the music itself. Many were quantitative or mixed-method studies. A Cochrane review of Music Therapy for Acquired Brain Injury (Bradt, Magee, Dileo, Wheeler, & McGilloway, 2010) presented an overview of randomized controlled trials (RCTs), providing a systematic review of seven music therapy trials to measure the efficacy of music therapy with this population. A song singing protocol for speech prosody was mentioned in one of the trials while the remainder utilized music listening and rhythmic and melodic improvisation techniques. One related article was found that addressed the use of unfamiliar improvisational music and familiar pre-composed songs to facilitate identity re-creation with persons with chronic neurological illness (Magee, 2006).

Music Therapy with TBI Post-Injury

The point in TBI recovery at which rehabilitation therapies are begun is an ongoing topic of interest in research studies. Research in the TBI recovery field has examined post-injury music therapy application at various stages of recovery, with some reports concerned with early music therapy interventions for coma recovery and low awareness states (Daveson, Magee, Crewe, Beaumont, & Kenealy, 2007; Formisano, Vinicola, Penta, Matteis, Brunelli, & Weckel, 2001; Kennelly & Edwards, 1997; Magee, 2005). Formisano et al. (2001) called for immediate implementation of therapy upon coma recovery, warning of a negative final outcome if delayed. Braunling-McMorrow, Dollinger, Gould, Neumann, and Heiligenthal (2010) stated that earlier (under 6 months post-injury) rehabilitation interventions showed the greatest recovery prognoses, but findings showed that some learning was seen even when rehabilitation began much later. The amount of time post-injury was not mentioned for the later starts. The aforementioned study was conducted in a residential rehabilitation setting, a sometimes-busy environment differing greatly from a relatively private home suite such as the one in which Danielle resides. Braunling-McMorrow et al. (2010) evaluated patients at six different times during their recovery, including one follow-up evaluation 1 month after music therapy sessions were ended, and positive results were prevalent with those patients receiving music therapy, showing gains in psychomotor initiations and a significant reduction in negative behaviors such as agitation.

Gilbertson (2006) wrote about music therapy in early neurorehabilitation with TBI, using an extensive review of the related literature to make a point for the use of music therapy in reducing isolation through the therapeutic relationships that develop between client and therapist. The author showed the link between early music therapy interventions and “clinically significant

change in musical expression, communication, agency, emotionality, motility and participation” (p. 685).

There is a lack of music therapy studies where music therapy was cited as having been introduced later than 8 years in the recovery process (Baker, Wigram, & Gold, 2005), and none was seen to address a single patient living in the family home. Most looked at work with inpatient acute or sub-acute patients.

Songs with TBI

The utilization of songs in varying forms is prevalent throughout the TBI literature. Baker and Wigram (2004) studied the connections between singing familiar songs of participants’ choice, and increased mood, tension reduction, and increased vocal flexibility. A focus of this article was the neurological basis for melody in both song and speech; the research was designed to examine the contributions song singing may make in improving vocal intonation in speech. Baker, Wigram, and Gold (2005) also found that a protocol utilizing song singing and vocal exercises positively affected vocal range of subjects with TBI, as late as 8 years post-injury. The researchers explored a connection between participation in music therapy and an improved mood state of the participants, leading to more relaxed voices and enhanced vocal range and inflection (Baker et al, 2005). A connection may be made to Tamplin (2008) who studied the effect of vocal exercises and singing on dysarthric speech, and had similar findings as a result of singing techniques. She cited the motivational aspects of music and pointed out how the similarities between singing musical phrasing and speech prosody can assist persons in recovery from TBI with recovery of speaking abilities.

A study by Magee (2006) including both improvised music as well as the use of familiar pre-composed songs emphasized the neuro-cognitive, emotional, and psychosocial benefits of

such a protocol with persons with Multiple Sclerosis, a progressive neurological disease presenting challenges similar to those in TBI recovery. Addressing issues such as the ways in which chronic neurological illness robs the client with TBI of a sense of self, Magee sought to offer opportunities for rebuilding identity through participation in improvised and sung music.

Another critical area of TBI treatment examines adjustment to life after regaining consciousness after injury. This can be challenging on many levels, particularly in the areas of coping with new cognitive and physical limitations, and the loss of a defined sense of self (Baker, Kennedy, & Tamplin, 2005a). The use of songwriting in music therapy with TBI is becoming more widely researched and reported (Baker, Kennelly, & Tamplin, 2005a, 2005b, 2005c; Baker, Wigram, Stott, & McFerran, 2008, 2009; Jones, 2006; Tamplin, 2006). Some studies focused on themes within the songs written by clients (Baker et al., 2005a, 2005b, 2005c). The same 11 TBI clients ranging from 6 years old to 60 years old were the subjects in all three reports. In one study, the authors utilized songwriting as a means of helping clients to express thoughts and feelings, and the other two related articles focused respectively on age and gender differences in the themes that emerged as therapy work progressed (Baker et al, 2005a, 2005b, 2005c). The writing of songs in therapy for TBI clients was found to be helpful in communicating challenging emotions (Baker et al., 2005a). Findings of the gender-focused study provided a basis for the use of lyric writing in expressing feelings, particularly for males, when verbal communication may prove difficult. Since frontal lobe damage in many TBI patients causes a flattening of emotional range, songwriting techniques utilizing lyrics in music therapy could provide a means of improving function in this area.

Re-creative music therapy was described in some studies as part of a larger therapeutic procedure, but only one specifically focused on a form of this technique (Tamplin, 2006). This

method is one that engages the client in music reproduction, and would include the singing of pre-composed songs (Bruscia, 1998). Tamplin's (2006) "Song Collage Technique" study created an innovative form of song re-creation, where a variety of song lyrics was offered to a client with cognitive impairments in order to "cut and paste" a new song based on lyrics and stanzas that resonated with the client in some personal way. The music therapist then created the music with the client, forming a new song that provided opportunities for the client to make choices and exercise control over the song project, leading to increased feelings of self-worth and empowerment.

Lyric Analysis

O'Callaghan and Grocke (2009) compared lyric analysis methods from nine analysis studies performed by music therapists who utilize songs in their practice. Results, according to the researchers, "reflect how song writing can enable clients to express what is believed to be important when enduring hardship or pathological conditions" (O'Callaghan & Grocke, 2009, p. 320). Therapists' methods were compared to determine similarities and differences in therapy styles. The authors offered that lyric analysis may offer music therapists a better understanding of their clients' experiences by providing opportunities for developing "rapid empathy and assessment, and are hence important to analyse in therapeutic settings" (O'Callaghan & Grocke, 2009, p. 327).

Analysis of Musical Form

Lee (2000) wrote that "music is the one ingredient that gives music therapy its unique potential and effect," but that it is often overlooked as researchers strive to describe results in terms of empirical data (p. 147). He continued by saying that few studies actually delve into the musical "building blocks" that could decode improvisation's musical intricacies, even though

there are many studies that focus on the process of improvisational music therapy and the inherent “clinical implications” (p. 147). There was a lack of studies on melodic interpretation and analysis in pre-composed music, although one work was found to describe melody, its history, and its importance and connection to our personal memories and life experiences. This was the introduction for a method of analysis that studied improvised melodies created in music therapy work (G. Aldridge & D. Aldridge, 2008). Levitan (2008) postulated connections between the evolution of the human brain and popular song genres and wrote that music and song have served as “a form of emotional communication” throughout time, but no detailed musical analysis was seen (p. 60). More studies need to be undertaken that analyze the music form of pre-composed songs utilized in music therapy with TBI to determine their effectiveness in achieving recovery goals.

Overall, the reviewed studies primarily analyzed the use of music therapy techniques in addressing goal areas in the field of TBI rehabilitation in early stages of recovery. There was a dearth of articles found containing research on music therapy begun with TBI patients more than 8 years post-injury, although there are many studies related to this area.

METHOD

This qualitative narrative case study reviews the music therapy work of Danielle, a woman in her 30s with TBI, 11 years post-injury, and investigates the use of songs in her music therapy treatment that occurred over a 3-year period of weekly therapy sessions. “Therapeutic Narrative Analysis” (G. Aldridge, & D. Aldridge, 2008), a qualitative research design, offered a framework for integration of clinical notes with session transcriptions and music therapy analysis (p.71). Themes that emerged from this analysis form a picture of Danielle and her life before and after her injury.

Participants

Participants in the study included Danielle, her mother, her primary care aide, her art therapist, and the researcher/therapist. Purposive sampling was the method used to determine interview participants. Interviews were conducted with Danielle's mother, her full-time primary care aide, and her art therapist. These members of the client's therapy team were chosen for their understanding of the music therapy work and their perspective of any changes seen in the client for the past 3-year period represented in the study. Diverse ethnic and racial groups made up Danielle's therapy team, and ages of the participants ranged from mid-30s to early 70s. Pseudonyms for participants were used in all written and transcribed data.

Procedure

Data sources for the study included notes kept by the therapist-researcher of songs used in the therapy sessions, recordings of therapy sessions, interviews with the therapy team members, and lyrics from songs utilized during this time. Data analysis exposed themes pertaining to the client's experience before and after recovery. The examination of songs included the use of pre-composed songs chosen and sung by the subject with the therapist, and improvised songs and chants written jointly during music therapy sessions. The significance of the songs to the client's experience was uncovered through the analysis of the lyrics and the determination of emerging themes in the lyrics. Songs were transcribed into music notation and analyzed with regard to melody, rhythm, tempo, dynamics, and song structure. As themes emerged and were noted, they were compared to stages of the client's progress in therapy over the 3-year period of weekly sessions. This was an unintended area of study, but as often occurs in qualitative research, was found to be one that enhanced the significance of the research results.

Song data. Titles and lyrics of pre-composed and improvised songs utilized over the 3-year period of music therapy sessions have been documented in my written notes, stored in a secure location in my office, and digital audio recordings of songs sung in sessions were stored on my H2 recording device. A signed consent form was required to record Danielle's music therapy sessions and permission was given by her parent/guardian. (See Appendix C). Music recordings were kept in my possession on the digital device and on my computer in secure files, and access to the work was limited to the thesis committee and me. I will keep recordings for 1 year after the study is completed, after which time they will be destroyed in order to ensure confidentiality of the participants.

Interviews. Interview participants received letters of informed consent (See Appendix B). Signed consent forms were required for interviewees' participation in this study. Interviews with participants were approximately 30 minutes in length and were recorded on a digital recording device for transcription. A sample questionnaire with open-ended questions was utilized for interviewees, and was standardized for all participants (See Appendix A). Interviews were conducted during participants' nonworking hours in their homes. Participation in this study was voluntary, and no compensation was offered to participants. All interview recordings were kept in a secure location by the therapist-researcher during the length of the study, and will be destroyed 1 year after the study's completion.

Trustworthiness. Ethical safeguards for this research study included peer debriefing and member checking. Three informal peer meetings were held approximately once a month during the course of this study for emotional and academic support. Informal meetings were also arranged with therapeutic professionals--colleagues outside the music therapy community--

approximately twice a month in order to provide a different point of view, help with writing clarity, and general support, motivation, and redirection.

Member checking is another method of ensuring credibility as a qualitative researcher. Participants in this study were offered opportunities to review the inclusion of pieces of their interviews in this writing in order to ensure interpretation of the data was consistent with their own experiences.

Presentation of Findings

My findings are being presented in a variety of narrative forms in the interest of telling one story of how songs were used in music therapy with a woman in recovery from traumatic brain injury. The use of critical incidents, dialogue from music therapy sessions and interviews, and excerpts of music notation are used to illustrate the sessions. Nochi (1998), in his research with TBI survivors, suggested that a person's story can be explored through the use of narrative and evocative prose. Ely (2001) agreed when stressing that although scholarly writing must be concise and clear, the author of a study must also find a personal voice or style of writing that presents "the context we have studied as fully and richly as possible" (p. 170). I wanted to write my findings in a way that allows Danielle's process to be shared, primarily shedding light on the clinical use of songs in her music therapy treatment and providing information that can be used by other therapists working in the field of traumatic brain injury.

Researcher's Stance: Personal Source of the Study

Songs and music have traveled with me on my own journey ever since I can remember. When I was a very little girl, my father, a professional baritone, would play the piano and sing to me as we sat side by side on the piano bench. I remember accompanying myself on the same instrument, belting out the lyrics to "Some Enchanted Evening" from "South Pacific" when no

one was listening, a welcome respite from the Bach Inventions I was practicing. It was the first popular music I had seen, and I found I liked singing the lyrics and the melodies.

Early Saturday mornings were “opera time,” and the pre-stereo monaural horn speaker in the corner of the living room blasted Puccini, Verdi, and Wagner—my father’s favorites—as I put a pillow over my ears and tried to go back to sleep. I rarely remember anything other than classical music being played in our household, but as I became a teenager and discovered the popular songs of my peers, I embraced the lyrics that seemed to mirror perfectly my feelings from a painful childhood. Through the years, songs have remained a constant companion on my life path, and I found in them a healing balm that I had not yet discovered in my rigid classical piano and violin training.

After beginning my music therapy studies I discovered music improvisation, and a new dimension of music that fed my soul was uncovered. Being *in the moment* with music while playing and singing exactly what was in my heart with no printed sheet music in sight was terrifying and thrilling at the same time. There were layers of my musical being I had never encountered before. As I sang I found myself asking where that voice had been hiding. What was most surprising to me was that the freedom and self-acceptance I found in improvisational music re-opened the long-closed door to my classical music world. I began to return to classical violin and piano studies, playing from this new place I hardly recognized as myself. I started to sing with deeper understanding, at last able to give musical voice to all that had been buried inside. Songs that came from a newly discovered part of me became and continue to be my medicine and my restoration.

As a music therapy student in nursing homes, psychiatric hospitals, and neurological disability rehabilitation facilities, I witnessed the power of songs to elicit speech, memory, and

movement in persons who had serious cognitive and physical disabilities. I was fascinated by the sudden outburst of clear and melodic vocals by a man in his 80s with advanced Parkinson's disease, who had been frustrated and unintelligible moments before the therapist started to play a familiar tune on the guitar. On piano, I accompanied a group of clients with TBI as they performed their original theme song for family members and therapy staff. I led a group of homeless men with psychiatric illness in drumming and chanting, where many of these forgotten souls bravely called out their pent-up rage, frustration, and pain. I wept alone in my instrument room after leaving a music therapy session with an 11-year-old boy hospitalized and isolated for nine months in the Bone Marrow Transplant Unit where we created a song together from his poem about how music and African drumming helped him forget his pain and sadness. All of these experiences led me to want to understand more about the power of songs and to explore the aspects of song that had this ability to transmute moments in these people's lives.

Clinical Orientation

My clinical orientation stems from the Nordoff-Robbins philosophies in music therapy. Resonating with my own humanistic beliefs, this approach was one that appealed to me from the first time I heard it described in my beginning music therapy studies. Turry (1998) wrote that in Nordoff-Robbins music therapy, "the therapist attempts to access and direct the transpersonal forces in music," utilizing music as an agent of therapeutic change (p. 162). The idea that there is "inherent, inborn musicality" residing in everyone "regardless of pathology" remains the foundation of my own practice (Turry, 1998, p. 161). The client-centered work with its creative process for both client and therapist sees only ability in those who may be viewed in very different ways outside of the music therapy sessions (p. 161).

Carl Rogers (1961) wrote that the need to self-actualize “is evident in all organic and human life....The tendency to express and activate all the capacities of the organism...enhances the organism or the self....[and] exists in every individual, [awaiting] only the proper conditions to be released and expressed” (p.35). My music therapy work is concerned with providing a safe, supportive, and accepting environment where the client’s inner “music child” can open and expand through the relationship created in the music (Nordoff & Robbins, 2007, p. 3). Rogers’ concept of “unconditional positive regard” expressed by a cherished therapist and mentor was a guiding light on my own journey through a course of personal psychotherapy, and I attempt to emulate this manner of viewing clients in my own practice. My philosophy in music therapy for all of my clients parallels that of Gladis (2008): “My model is not illness-based. It is based on the potential for health and wholeness that we all possess” (p. 19).

SONGS IN THERAPY

Songs Pre-injury

In our first session together, Danielle began to share with me her preference for songs from artists of the turbulent and politically charged 1960s, and I was surprised to hear that “Peter, Paul, and Mary” was her favorite group, considering her young age. She explained that even though she was born in the late 1970s, she imagined she must have heard this music played by her older brothers and parents.

My first session with Danielle began with her care aide telling me that Danielle had just been singing, “If I Had a Hammer,” by Peter, Paul, and Mary. I was informed that the aide’s husband enjoyed singing with Danielle, and discovered they both liked this song. I began to play the chords of the song on the guitar, waiting to see how much of the song she retained in her long-term memory. I also wanted to assess Danielle’s pitch, prosody, and vocal range abilities as

she sang. I chose the key of G with a starting note of G, knowing the melody spans an octave and that the mid-range pitches would be a good starting place to evaluate her voice. As we began, Danielle confidently forged ahead, singing almost all of the lyrics to every verse from memory as I supported her by singing the melody, filling in any words I could remember. Her vocal quality varied greatly, opening with a spoken sound in a low pitch and becoming breathy and almost inaudible, then climbing suddenly to very intense, unmodulated, and loud higher pitch as she became excited. She struggled with her ability to regulate her pitch or volume (Baker & Tamplin, 2006). She was, however, singing/speaking the phrases with perfect rhythmic syntax, smiling throughout our music-making. When we finished singing, I asked Danielle why she enjoyed that particular song, and she replied: “It’s about things I think are important, like love and justice,” repeating some of the ideas in the song lyrics. I didn’t know enough yet to detect whether she actually believed this or was trying to give me an answer that would please me. We were just beginning to get acquainted in the music.

We continued with familiar Peter, Paul, and Mary songs with another of her favorites, “Puff, the Magic Dragon.” The song began on the tonic in the key of D:

Puff...

and descended to the dominant chord, A:

Dragon...

Resting on the fifth:

By the Sea...

then to the fourth and eventually back to the tonic:

Hona Lee...

The chords were played in a major I, V, IV progression throughout most of the song, and the chorus returned in between each verse, providing a safe haven for Danielle to return to, as the song verses repeatedly landed on the V chord and resolved to I each time. “The most important pitch is that which corresponds to the tonic,” wrote G. Aldridge and D. Aldridge (2008). “Many melodies start and end on the tonic, moving away from the stability and returning to it” (p. 31). “Melodic anchoring” refers to the “psychological force...[of] expectation” when one longs for resolution and a return to an “anchor point” (pp. 31-32). The authors refer to this occurrence in terms of resolution of dissonance, but it also takes place with the plagal and perfect authentic cadence as in folk or Christian church music song structures. In almost all of the songs Danielle and I sang together, the return to tonic at the end of the song was her solid ground. When I asked Danielle to describe her feelings about the song after we sang the words, she replied, “I don’t know. I just like the words.” In further attempts to elicit feelings about song lyrics, I noticed Danielle was unable to verbally describe any depth of emotion, but that she had been very animated when singing. “Music can often express feelings more accurately and sensitively than words, and is able to express subtlety” (Baker & Tamplin, 2006, p. 199). Music became the language of the emotion Danielle could not access in words, and provided her with opportunities to express herself. It also provided ongoing positive experiences with her vocalizations and helped her to see her singing abilities in a new light. Zwerling (1979) wrote of his experiences as a psychiatrist and advocate for the use of creative arts therapies: “[T]he creative arts therapies evoke responses...more directly and more immediately than do any of the more traditional verbal therapies” (p. 843).

As our work progressed, Danielle began to share some of her stronger memories, predominantly those from her high school and college years. I learned that Danielle was editor

of her college handbook for female students on campus, and that she was a vocal campaigner for women's equality. She spoke about this job often throughout our work, and said she missed being there and missed writing. Baker, Kennedy, and Tamplin (2005a) wrote that the challenge of facing one's limitations and grieving losses after TBI is one that emerges in songs created or chosen by survivors in music therapy. Although Danielle was unable to openly grieve in an obvious show of tears as a result of the location of her brain injury, she was aware of the loss of her past physical abilities and very active social life along with the independence she had treasured as a young adult.

A common musical thread began to show as Danielle and I reviewed and sang songs from her pre-injury past. Songs we chose together from her collection of CDs were played to get an idea of her favorites (Magee, 1999). When I played songs from many of the discs, however, she showed little interest or recognition of lyrics. I returned to the folk music of Peter, Paul, and Mary, Bob Dylan, Pete Seeger, and Simon and Garfunkel, where the basic chord structure was always a simple I, IV, V progression with some variations. What was it about this well-known musical form that ignited Danielle's enthusiasm? Could it have something to do with folk music's similarity to the two- and three-chord structure of children's songs? Perhaps the safety and the simplicity of these song structures created a kind of musical holding place for her and created a space where she could feel free to be herself and explore in the music (Austin, 2004).

In Session 23, about five months after our start of therapy, I discovered that another favorite of Danielle's was "They Might Be Giants," an unconventional band with a reputation of writing silly songs that appeal to both children and adults. She told me she had attended many of their concerts when they came to the New York area. I had discovered one of their songs, *Violin*, a few years before, and remembered that the only lyric word in the song is, "Violin." When I

learned of Danielle's enthusiasm for this group's songs, I asked if she knew this one. I began to sing it as she laughed and became excited, joining me with her own version of the lyric:

"Danielle Lin Lin Lin..." Her middle name was Lynn, and she had adopted the song as her own, creating her own lyrics while in high school. We began again, this time with my joining her on her lyric. On the recording the song was sung in playful imitation of an opera singer in a Classical style reminiscent of Mozart, and was another song with a basic I, IV, V progression. Its lyric is sung over and over in three repeated ascending triads, starting and ending on the tonic.

This was the first time I witnessed how Danielle's sense of humor in her pre-injury life had extended into her music tastes. This information was useful in choosing new groups and songs for her memory and cognitive work. Danielle often made facetious comments in music therapy sessions, laughing loudly and at length at her own jokes and seeing the humor in many topics that arose in our discussions. This was a part of her identity she had apparently not lost to the effects of her brain injury, and I was able to use humor both in pre-recorded and improvised work to connect with her on this level.

Chants

During the first few sessions with Danielle I was assessing her musical tastes while creating a safe therapy space through the use of her familiar music (Magee, 2006). I listened to her musical preferences and printed out lyrics to the folk songs and popular songs from the years leading to the time of her accident in 1998. I was the one who needed the lyrics, while Danielle had almost every lyric memorized to every song she chose. We sang the words together and she shared with me as pre-injury memories were invoked by the music from her past.

In Session 8, 2 months into our work, I introduced a Native American chant taught to me years ago by a musician friend entitled, "The Ocean Refuses No River." I was searching for

songs that would give voice to some of Danielle's personal interests in her favored music genres as well as in her pre-injury young adult life. I remembered some chants I had heard sung on a recording by the women's a capella ensemble, Libana, and thought they might be of interest to Danielle. In the chants I found many themes similar to the ones in the earlier folk songs we sang: peace, love, universality, women's strength, and ecological concerns. I thought she would relate to these pieces, and I believed the brief song duration and relatively short lyric phrasing of these lovely chants would facilitate incorporation of the new words and melodies (Patel, Peretz, Tramo, & Labreque, 1998).

Danielle responded immediately to the chant, "The Ocean Refuses No River," (see Musical excerpt 1) with great enthusiasm, albeit atonally. She was able to perfectly imitate the prosody of the phrasing after I sang the song through one time: "The O-cean re-FUS-es no RI-ver, no RI-ver," singing the twice-repeated "Hallelujah" with me at the end of the fourth line with a sudden and sharp elevation in vocal pitch and volume, a reaction I noticed when she was feeling emotionally involved with the lyrics. Her strong religious background may have been the reason for her connection to the word, *hallelujah*: It is often found in church hymnals in both old and new Christian songs.

The first interval of the song opens with the tonic jumping to the dominant, creating a perfect fifth in the key of A minor, moving to an interval of a perfect fourth in the next measure. The tonic remains steady for the next two measures, and the line is repeated. I changed the chords to the relative major key for the "Hallelujah" refrain to create a lighter sound to reflect Danielle's joyful exuberance while singing these lines, moving into C Major, but still repeating the I, V, IV pattern. An A minor chord returns at the end of the song to tie it to the tonal feeling of the beginning and to create a feeling of wholeness.

After we sang this song for the first time, I asked Danielle what she thought it might be about. She replied, “The ocean represents God, and the rivers are human beings. It means nobody is refused love from God. God loves everyone, even people in wheelchairs.” This was to be a common theme for Danielle, and was a topic that recurred throughout our work. Even though she was in a positive mood much of the time when I saw her, she mentioned this in a few sessions: “People think I am worthless just because I’m in this wheelchair. I don’t want them to feel sorry for me.” Nochi (1998) found that persons with TBI often experienced feeling a “loss of self in the eyes of others,” and perceived that society “neglected their individuality” by assigning disability labels (p. 873). The music appeared to arouse Danielle’s feelings about her disability that she didn’t often speak of at other times, and she began to repeat this idea in following sessions. She continued, however, to ask for songs with more inspiring lyrics to sing in our sessions, stressing her belief in the importance of “staying positive.”

The Ocean Refuses No River

Traditional Native American

The O - cean re - fu - ses no ri - ver, no ri - ver. The o - cean re -

fu - ses no ri - ver, no ri - ver. Ha - lle - lu - jah, Ha - lle - lu,

Ha - lle lu. Ha - lle - lu - jah, Ha - lle - lu, Ha - lle - lu. The lu.

Musical excerpt 1: The Ocean Refuses No River

“Now I Walk in Beauty” was another chant that contained concepts attractive to Danielle (see Musical excerpt 2). She often spoke of gratitude for the privileges she felt she had in spite of her injury and its life-changing effects, and expressed positive comments about the lyrics.

Because Danielle’s short-term memory was an area of frustration for her in our sessions, I started to help her find words of new songs through gestural hints, hand movements I used to symbolize individual words (Church, Garber, & Rogalski, 2007). My hope was that the visual cue given in conjunction with the strummed guitar chords would stimulate her memory for the more significant and stressed words in the lyrics. When we began learning this chant I would point to myself, then point two fingers straight down and move them as if simulating someone walking to assist Danielle in recalling the first words of the song: “I walk.” Danielle took the hints immediately, using them to access the lyrics, and was eventually able to remember the song words without any assistance in many sessions. She also started singing the songs while using the gestures I had shown her as she sang, creating descriptive movement throughout the song.

I later discussed this phenomenon with Danielle’s speech therapist, and she referred me to writings on gesture and stressed words. My search led me to articles on the relationship between gesture, word retrieval, and memory. Church, Garber, and Rogalski (2007) found that “gesture that matches the content expressed in speech supports the processing of speech” in a study with abled participants (p. 137), and Krauss and Hadar (2001) noted the prevalence of gesture when people are attempting to locate a word in their memory, providing support for my interventions with the use of gestures in word retrieval related to song lyrics.

The accompanying chord structure played on guitar may also have played a part in triggering memories of the song lyrics for Danielle. The beginning chord, the tonic, moves to the minor iv chord and back to the tonic four times, ending on the tonic, E minor, to end the

chant. The open and somewhat mysterious feeling of the E dorian mode, and the minor i chord moving to the minor iv reminded me of Gregorian chants, with their lyric lines sung in the syntax of spoken prayers. I remembered Danielle's mother telling me that she played Gregorian chant CDs for her daughter every night of her 8-month-long coma to create a more peaceful environment where she lay in the often-noisy hospital intensive care unit. The Dorian mode is the most frequently recurring mode in Medieval religious music, and may have been heard by Danielle's subconscious many times over the course of her hospitalization (Huron & Veltman, 2007). It was possible that the musical memory of those chants was recalled by her subconscious with the ones I introduced.

Each song began with a slightly different rhythmic strum pattern as I played a few bars and hummed a few notes as an introduction. Danielle eventually learned to recognize the difference between songs as the opening bars began the tunes.

Now I Walk in Beauty

Traditional Navajo Chant

Now I walk in beau - ty. Beau - ty is be - fo - re me.

Beau - ty is be - hi - nd me, A - bo - ve and be - low me.

Musical excerpt 2: Now I Walk in Beauty

“Ancient Mother” was introduced toward the end of our second autumn together in Session 68 (See Musical excerpt 3). It was another song that lent itself to gestures as hints, and Danielle learned the words over a period of about a month, occasionally needing some assistance for word recall. This was a much more rapid acquisition of song lyrics than had occurred in past months, and I noticed her retention of these chant lyrics remained constant, even when I left a chant for a few weeks and brought it back to our sessions.

I originally played this song in A minor, moving to E minor and D minor, but after playing it a few times with Danielle, she said it felt “too sad.” I asked her what she meant and she answered that the music felt “sad,” and that the words of the song were sad, but that she thought it was a “good” song. I questioned why she said that, and her response was that “the earth is sad and cries because of people polluting it every day.” I played with some chord substitutions and Danielle agreed that it felt better to her with the addition of the major chords, which is how it remained for ensuing sessions.

At the beginning of this song’s introduction to our sessions, I used gestures for the first line of this song, putting my hand to my face as if I were calling someone:

I hear you calling

And mimed singing “La la la” for the next line:

I hear your song

Pretending to laugh to hint:

I hear your laughter

And running my finger down my cheek as I looked sad:

I taste your tears

In four sessions, Danielle was able to remember the lyrics and sing them completely while I sang only the beginning words of the phrase, “Ancient Mother,” for support. When she hesitated I added a gesture and she immediately recalled the word she was trying to find, laughingly saying, “Good hint, Pam!” As with “Now I Walk in Beauty,” Danielle began to use gestures to accompany the lyrics each time she sang the song, even after learning the lyrics. I was curious to see if Danielle could recall the lyrics without using her hands, and asked her if she could try to sing “Ancient Mother” without gestures. She said, “No problem, Pam,” and readily sang through all of the stanzas with her hands in her lap and a mischievous smile on her face, as if she were saying, “See? I told you I can do this!”

Ancient Mother

Traditional

Am G Am C G

An - cient mo - ther, I hear you ca - lling. An - cient mo - ther, I hear your

4 Am G Am F G

song. An - cient mo - ther, I hear your laugh - ter. An - cient mo - ther, I taste your

8 Am G Am C G

tears. An - cient mo - ther, I hear you ca - lling. An - cient mo - ther, I hear your

12 Am G Am F G Am

song. An - cient mo - ther, I hear your laugh - ter. An - cient mo - ther, I taste your tears.

Musical excerpt 3: Ancient Mother

Danielle's Songs

Danielle's mother gave a party in January every year to thank the therapy team members for their work with her daughter. The party also served as a time when the entire team could meet face-to-face and discuss goals for Danielle and issues relating to their work. At the end of December, I asked Danielle if she would like to compose a song to sing for the team, and she readily agreed. Danielle and I created this song together, about 5 months into our work together (See Musical excerpt 4).

We began with "brainstorming" the lyrics (Baker & Wigram, 2005, p. 123). The authors described a process of "Therapeutic Lyric Creation (TLC)," where the client and therapist discuss significant issues and agree upon a theme for possible song lyrics. The most typically used method for songwriting for emotional expression with persons with TBI, TLC creates many opportunities for empowerment and "creative control" through client choices (p. 122).

Composition of the musical genre, melody, and chord structure follows the lyric writing, according to Baker and Wigram (2005). For non-musicians, composing lyrics usually feels less threatening than tackling the music, and proves a less daunting first undertaking in writing songs (p. 126). "It is important to build the clients' confidence with a task with which they are more comfortable before introducing a more challenging or demanding task" (p. 126). Baker and Wigram wrote that, "Providing maximum opportunity for the client to contribute to the music composition ensures greater ownership of the completed song" (p. 127).

Danielle said she wanted to thank everyone on her team for their work with her, so I asked how she would like to start the song. She said, "How about just saying that I want to thank everyone?" I offered, "I want to thank you," and checked with her to make sure the phrase accurately reflected her words. We moved to the next lines and verses, with Danielle needing

little guidance in what she wanted to say. I shortened some of the lines to fit the other lyrics, and needed to redirect some repetitive thoughts, but overall, the lyrics were Danielle's creation. We spoke the words of the created lyrics to determine the syntax of the phrases, and created the rest of the melody together with syntax in mind.

I offered a choice of chord structures to see which ones felt more right to her for her song, beginning with a major chord progression of D, G, A, as I felt this might provide a container similar to the folk songs we had been working on. Taking into consideration Danielle's difficulty in initiating any musical ideas, we made the decision to create the melody together after she was offered a variety of intervals that would open her song. Asking if she wanted the music to move "up or down," she told me preferred the first line to go in an upward direction, reflecting her previous requests to keep the music feeling positive (Baker & Wigram, 2005, p. 127). She then chose the ascending major sixth over the others I sang for her (a major third, a major fourth or major fifth), saying it "felt more like I'm thanking everyone." To accompany her words, match the syntax of the lyrics, and find a key that worked for her vocal range, I began by picking the individual notes in D, playing triplets to each beat, creating a feeling of gentle movement. Instead of playing a G major chord to end each line, the choice to move to E minor felt as if it matched the more open feeling of gratitude that was emerging as we sang the first words:

I want to thank you

I moved to A for the second line,

For all of your service

and to E minor on the third:

For coming in contact with me,

Back to A and resting there for the last line:

*The “Lucky Lady...”*²

I asked Danielle how she felt about the chord movement as well as the meter, and she replied that the progressions fit her song and how she wanted it to sound. We sang it through a few times, continuing our rehearsals up until the party 4 weeks later. In the last verse where she is thanking her “Heavenly Father for giving me my life,” she added the words, “two times” a few weeks later as we sang it together, making reference to her very real brush with death. This was a spontaneous move on her part, and was not prompted by me. She asked me to make this addition a permanent part of the lyrics, saying that it was an important piece. With the help of a lyric sheet, Danielle performed the song for her therapists and their guests as I accompanied on guitar and provided vocal support. She was happy to tell everyone that this was the first song she had ever written, and that even with her “terrible” voice, she felt glad to sing it as a way of letting her team know how grateful she was for their work.

² The phrase “Lucky Lady” was created by Danielle as a mnemonic device to help her remember her first name which contains two letter Ls.

Danielle's Thank You Song

Danielle

I want to thank you for all of your service for coming in contact with
me, the lucky lady, I want to thank you for helping me devel-op all of my talents in
music and art and
al- so in the phy- si- cal world. I want to thank you for all of your gifts for
helping me to get better and for helping me to face the world. I want to thank you especially
Mom and Dad for standing behind me and loving and supporting me in my ev'ry move. I want to
thank you Especially my Heavenly Fa-ther For giving me my life (two times) and
just so you know, this is coming from the bottom of my heart.

Musical excerpt 4: Danielle's Thank-You Song

*I want to thank you
For all of your service,
And in coming in contact with me,
“The Lucky Lady”*

*I want to thank you
For helping me to develop
All of my talents in music and art,
And also in the physical world.*

*I want to thank you
For all of your gifts,
For helping me to get better,
And for helping me to face the world.*

*I want to thank you
Especially Mom and Dad,
For standing behind me and loving me,
And supporting me in my every move.*

*I want to thank you,
My Heavenly Father,
For giving me my life (two times),
And just so you know,
This is coming from the bottom of my heart.*

Example 1: Lyrics, Danielle’s Thank-You Song

The first chant composed by Danielle (See Musical excerpt 5) was an idea she had during Session 122 as we were discussing new song possibilities. I asked her what she might want to say if she were to write her own chant: “What would you want other people to know about you?” Her reply was immediate: “That I am surrounded by love.” The next lines were prompted

by my asking what else she wanted to say about being surrounded by love, at which point she said, while pointing to herself and then to me: “Love is within me; love is within you.” I asked if we could make it complete and give it emphasis by repeating the first line, and she agreed: “I am surrounded by love.”

I created the music that accompanied these lyrics to mirror the direction, syntax, and meaning of the words. The ascending and descending melody for “surrounded,” seemed to want to wrap itself around the word, and the 6/8 time created a rocking motion that imparted a tenderness and a feeling of being held to the meaning of the lyrics. I asked Danielle for her opinion after being shown how her lyrics fit into the 6/8 rhythm, and she agreed that this was the way she wanted it to sound.

I am Surrounded by Love

Danielle

Am Em Am DmAm Am Em Am DmAm

I am su - rroun - ded by love. I am su - rroun - ded by love.

5 C G F G Am Em Am DmAm

Love is with - in me. Love is with - in you. I am su - rroun - ded by love.

Musical excerpt 5: I am Surrounded by Love

Danielle initiated the writing of her second chant the week after finishing “I am Surrounded by Love.” She drew upon ideas from previous pre-composed chants, and said she wanted to acknowledge that, “everything comes from God.” (See Musical excerpt 6). The chord

sequence ended up more like a doo-wop song as we played with a variety of chord choices, and this was the one she said she liked best. I, vi, IV, vi, IV, vi, IV, V, leaving the melody hanging and open at the end on the V chord. I was interested to see if Danielle would be able to vocalize the tonic on her own to end the phrase, but when I kept playing, she wanted to continue to return to the beginning. After a few repeats, I ended on the tonic with “Umm,” and Danielle followed my lead. After two more sessions she learned and sang the new ending without my leading her.

All Elements Come from God Above

Danielle

C Am F Am F Am F G

All el-e-ments come from God a-bove. Earth, A-ir, Fire, and Wa-ter.

5 C F Am F Am F G Am

All el-e-ments come from God a-bove. Earth, A-ir, Fire, and Wa-ter. Umm.

Musical excerpt 6: All Elements Come from God Above

One of Danielle’s later improvised songs, “Seize the Day,” is still in the process of being finished at the time of this writing, so I do not yet have a completed music excerpt to share. The beginning of the creation of the melody was notable, however, so I wrote about a piece of the process. This song was a development that arose from a research-based memory task that utilized “preserved aspects of memory,” and was introduced to the therapy team by Danielle’s

speech therapist (Fridriksson, Holland, Beeson, & Morrow, 2005). The task was reinforced in subsequent art therapy and music therapy sessions. Danielle had noticed the term, “Carpe Diem,” while reading a newspaper article about finding the good in each day, and the idea appealed to her. Each member of the therapy team was to develop cues to help her remember it, so I suggested writing a song using the English translation, “Seize the Day.” I also asked her what she might want to share with others about her recovery as it applied to this phrase. After our brainstorming discussion had exposed some lyric ideas, Danielle finished each line of the song without my adding any words.

As we moved into the melodic creation, I then offered some choices of intervals in C major for the opening of this song, including a major third, a major fifth, and an octave beginning on the G below middle C. I chose the key of C because Danielle had wanted to play her C major harmonica as an instrumental accompaniment to her new song as I sang the words she designed. Danielle wanted the melody line to start with an upward motion, one that would affirm her desire for a more positive reflection of the opening line, “Seize the Day,” and with a definitive response quickly said she preferred the octave to support the words. Nordoff, in Robbins and Robbins (1998), spoke of the octave as “an ego experience,” one in relationship to “outer experience” (p. 37). Danielle was ready and excited at this point in her therapy to make this gigantic leap in music, affirming her newfound self-assurance and musical abilities, and mirroring her growth in other areas of recovery. When we sang the octave together, she was able to accurately land on the high note of the octave, G above middle C, a triumphant sign of her musical accomplishment. Her emphasis on the word, *day*, was a declarative statement of her personal view of her life both before and after her injury: that one should grab onto every day and decide to be happy, “No matter what bad things happen.”

*Seize the day! Every day!
No matter what bad things happen
We should all be independent
And make our own choices
According to what we would like to see.*

*Seize the day! Every day!
It could be hard sometimes,
But we all have to be independent
And learn to be strong
So that we can all be happy!*

*Chorus:
No matter what other people say,
Don't let anything stand in your way
Just remember to seize the day...
Seize the day, seize the day seize the day!*

*Seize the day! Every day!
You can do anything that you think you can do
And remember, nothing is impossible
When you take every opportunity
To seize the day, seize the day, seize the day!*

Example 2: Lyrics, Seize the Day

“Sure as the Wind” (Dash, 1994, track 2) was a chant I offered for our new closing song each week, replacing another song we had used in previous sessions (See Musical excerpt 7). I introduced the new chant after commenting on her seeming disinterest in the blues-based goodbye song I had been improvising with her and asking her if she would like to try a new song to end our sessions. I introduced the new chant in Session 53 to continue to encourage new memory acquisition through the use of unfamiliar lyrics (Baker & Tamplin, 2006, pp. 114-117). The last line contained the lyrics, “We will raise our *song* again,” and we sang it as such for

many weeks. Three months later, Danielle, who gave everything she liked “a two thumbs up” even before her injury, sang the last line of the closing song, spontaneously substituting *thumbs*³ for *song*, and laughing at her own joke. “We will raise our *thumbs* again,” she sang as she gave her musical “two thumbs up” approval to this new version. This independent action reflects Danielle’s indomitable sense of humor as well as her ability to begin to initiate change on her own within the music therapy sessions.

Sure as the Wind

Terry Dash

Am Em Am G Am Am Em

Sure as the wind my sis-ters, and sure as the rain. Sure as the

Am Em Am Am Em Am G Am

6 sun does shine. we will raise our [thumbs] a - gain.

↑
Danielle's
lyric
substitution } Session #83

Musical excerpt 7: Sure as the Wind

³ Permission granted by composer for lyric substitution (personal communication, March 22, 2012).

ANSWERING THE RESEARCH QUESTIONS

What occurs when songs are used with a woman with traumatic brain injury when music therapy is introduced 11 years post-injury?

The focus of this study was to examine what happens when songs are used in music therapy with a woman in her mid-30s with traumatic brain injury when the therapy was begun many years post-injury. Data from music therapy sessions and interviews with members of Danielle's therapy team was gathered and examined for results of therapeutic significance. Related questions addressed the relevance of melody, rhythm, and song structure, the role of music in helping Danielle reestablish her identity, the role of music in helping Danielle sing in spite of her negative messages about her voice, and the role of the music therapist in collaborative song creation.

The song data compiled and examined over the 3-year period of music therapy sessions with Danielle along with the interview data yielded many noteworthy results showing the effects of a music therapy protocol introduced a number of years into her recovery. The use of song developed into a primary tool and the best course of in Danielle's music therapy work and quickly evolved into the best course of treatment for her. The use of instruments that required fine motor control proved to be too frustrating, and my observations of Danielle's keen interest in songs and singing led me to explore re-creative and improvisational song methods in our sessions. Over the first 3 years of Danielle's music therapy sessions many results were seen in areas of cognition and memory, psychosocial improvement, and musicality. The memory improvements I saw in acquisition and long-term retention of new song lyrics over the course of our work together began to happen more and more frequently, and the lyrics and melody prosody of newly introduced songs required less time for Danielle to learn.

What Was the Relevance of Melody, Rhythm, and Song Structure?

The musical elements of melody, rhythm, and song form provided a container for Danielle's feelings of gratitude, frustration, and past memories. When choosing songs she knew, Danielle was "not just requesting the musical structures, such as the melody and harmony, but the implicit personal meanings and emotions of that song" (Magee, 1999, p. 210). The songs held very deep meaning for Danielle, and were "used to communicate something personal" about her inner life whether in "explicit or implicit" ways (p. 209). The use of music familiar to Danielle enabled her "to express a deeper 'real' self or, alternatively...to mask feelings which were too difficult for [her] to have openly acknowledged in words or music" (p. 209). Nonverbal changes in Danielle's facial expressions and more animated body language were noted during songs that held significance for her, and her vocal range, dynamics, and pitch accuracy increased when she was particularly "aroused" by a song's lyrics or meaning (p. 208).

A number of themes emerged from Danielle's song choices from her past as well as her improvised and new pre-composed songs. Themes embedded in the songs themselves that reflected her interests along with new themes relating to her view of herself as a young woman living with TBI and its effects, her life before her accident, and her feelings about her evolving musical abilities began to show up in our music and discussions.

Music played an important role in helping Danielle to create a new sense of ability in this realm where she believed she had little talent. Melody created in songwriting became an affirmation of her words in the lyrics—words that helped her tell her story in a new way, one that minimized limitations and encouraged artistic freedom. She was offered choices in every aspect of the music therapy sessions, allowing her to find her own way and to be more independent,

something that was extremely important to her, as illuminated by her words in “Seize the Day” (See Example #2).

Rhythm, while not “played out” on the drums for most of our sessions, was embedded in the music we sang together, and beats were emphasized with guitar strumming and stressed words in the lyrics. Danielle became finely attuned to the opening rhythms of my strumming patterns on the guitar, and learned to enter with the first line of a song upon the ending of the introductory few bars. She developed the ability to discern between different songs, both pre-injury tunes and those that were newly learned, and in our later sessions of the third year together began to sing the beginning words to most of our songs with fewer prompts.

The classic mainly three-chord folk/rock song structure in all of our songs was important in providing the musical support for Danielle’s singing, an area in which she had no confidence and one where she told me she expected to see little improvement. The familiar series of chords repeated in the music she chose and the music we created together offered a safe place for Danielle to explore her musical being, and my non-judgmental acceptance of her vocalizations allowed her to see herself in a new, more positive way. Over time, her singing became stronger and more assured, with many accurate pitches voiced within songs sung in sessions as her vocal apparatus gained strength through musical song activities. Danielle’s weekly protests about her singing voice initially made many times during our hour-long sessions gradually diminished, as I continued to provide musical support for her singing and assurance that I believed she could sing. I became her voice by using my own voice and guitar each time we sang, lending my musical strength and providing a musical “shoulder” on which she could lean. As we continued our work, most of the time her comments became less repetitive and more focused on the work at hand. Toward the end of the 3-year therapy period Danielle emphatically made a comment to

her certified nursing attendant who shared it with me: “Everyone still tells me I can’t sing, but I don’t listen anymore. I believe I can sing now because my music therapist says I can.” (personal communication, February 19, 2012). Her singing became a reflection of this newfound musical self.

What Was the Role of Music in Helping to Reestablish Danielle’s Identity?

One of the greatest challenges in TBI recovery is adjustment to the many changes in life post-injury (Baker et al., 2005a). Living with a disability such as TBI that has an impact on memory, physical functioning, communication, and mood, among other effects, is a frightening prospect for those who are traveling the recovery path and who have had a life of ability pre-injury. Rimmon-Kenon asks, “What happens when the present is so different from the past that subjects experience themselves as ‘others’?” (2002, p. 10).

Aigen (2005) wrote that “...emotional expression through any means is a basic human need,” an idea I saw reflected in Danielle’s work in music therapy (2005, p. 84). Much of rehabilitation for TBI focuses on managing symptoms and correcting behavior impairments, but offering venues for the processing of emotions and helping survivors to rebuild identity through creativity is essential to the recovery process. A fine artist before her injury, Danielle’s creative abilities in music burgeoned from a place she had begun to access with her art in art therapy. She had attended art therapy sessions for a few years before beginning music therapy, but had not been actively using her singing voice since before her accident. Even though she identified herself as an artist and surely not as a musician, she remained engaged in music therapy sessions throughout the 3 years, and began taking the initiative on new music projects.

Baker et al. (2005a) wrote that a major theme in music therapy with TBI is the challenge of how to “integrate their identity as a person with a disability into a cogent sense of self” (p.

205). Danielle's preferred songs became a means for her to connect with her past in a way that helped her access memories of events that were important to her, supporting her in her reestablishment of her identity post-injury (Nochi, 1998). Her improvisations opened up a "new continuity to replace that which was ruptured" (Rimmon-Kenan, 2002, p.10).

Danielle's first and subsequent attempts at writing her own songs with my help showed the strength of her will and her spirit. The choices she made with the songs' melodic directions and feeling provided by the chord progressions illuminated her desire to be part of a larger community. In describing Steiner's interval concepts and the use of the major sixth, Nordoff (in C. Robbins & C. Robbins, 1998) said, "With the interval of the major sixth...we move out more actively...we are carried out into the world...we step into the external world" (p. 37). In "Danielle's Thank-You Song," the opening major sixth mirrored her readiness to open her self in the safety of the therapeutic musical experience and her relationship with me.

How Did Songs Encourage Danielle to Sing?

For a woman who had received so much teasing and negative messages about her voice from her family members, this flight into the realm of songs and singing was a courageous act. Her early song choices were those remembered with nostalgia from her pre-injury life, and provided familiarity and a safe space in which she could begin to explore her musical self. Danielle looked forward to music therapy sessions each week because her songs would be there with us. Magee (1999) referred to the concept of a client "being met in the music," which Danielle experienced as her old song friends returned to greet her in our initial therapy sessions (p. 209), and continued to show up in the familiar song structure and themes utilized in our improvised songs. This was music that had defined an important developmental part of her life: that of young adulthood and growing independence. Introducing and playing them again in

therapy created an impetus for singing with their connection to her rich and fulfilling memories of her past.

Danielle criticized her voice each week for over 3 years, persistently repeating her mantra that she “can’t sing,” but sang with me each week in spite of these protestations. I continued to support her as we sang together, and from time to time would let my voice be softer to see if she would sing alone, but she always stopped her singing when I did this. She needed me to be her “voice” and her musical strength, borrowing my sound to help her find her own. Each week she was emotionally engaged in the music therapy sessions and over time I noticed her sung pitches began to sound more accurate with increasing frequency. She showed a new intensity in the strength of her voice as we continued the breath warm-ups on kazoo and with engaging vocalization activities, although she continued to need reminders to breathe while we were singing. At first unable to match my sung pitch voiced close to her ear, she became able to sing a tone with me for a few seconds. She found more confidence for singing in church, in the car, and in front of others.

While Danielle still needed some redirection to stay focused on our music activities, her verbal interruptions lessened during our sessions, and her very frequent repetition of phrases she had learned to help with her memory diminished somewhat. Creating her own songs and being reminded each week that she is capable of making music changed the way she viewed herself. The reported voicing of song in church, in the car, and at home reflected this change in self-perception. I envision this self-assured singing enduring as a part of Danielle’s daily activities.

What Was the Role of the Music Therapist in Creating Songs with the Client?

“Contact happens when the client hears herself being heard....[T]here is a...moment when the client hears that the music *includes* her, that she is being responded to in the music and

can possibly respond back” (Ansdell, 1995, p. 71). From the beginning, my music therapy sessions with Danielle were about finding ways to ensure that she was seen and heard as someone who was capable of making music. No matter how she thought she sounded, my view of her was always positive and was reflected back to her in the music we played together as well as in our discussions. This “unconditional positive regard” showed up in Danielle’s new view of herself as a capable musician (Rogers, 1961, p. 62). She wasn’t just a listener anymore.

As we started to get to know one another in the therapy sessions, I provided as much normalcy in our conversations as possible, while still maintaining what I call “flexible boundaries.” I wanted to maintain a natural flow in our musical and verbal interactions in the attempt to reduce the “strangeness” Danielle may have been feeling in the newness of the music therapy environment and often used humor as a way to create “a relaxed atmosphere of mutual respect and trust” (Strange, 1999, p. 152).

My musical role varied depending on what methods we were utilizing during the session. I found that with every vocal or instrumental activity I remained in the role of leader, but always encouraged Danielle to be actively engaged in the music. With her protests that she wasn’t a musician, at first she wanted to hold back and allow me to play and sing for her while she listened. Many times during most of our sessions in our first year together I had to strongly encourage her to play and sing with me, letting her know that we were making music *together*.

The role of therapist with someone who has limited capacity for initiating song ideas or choices is crucial. Allowing the client to grow and develop while still providing most of the structure in the sessions is a balance I found myself creating with Danielle. As with Magee’s (1999) work, “within the song sessions the musical material relied heavily on the therapist” (p. 205). In addition to offering choices within our song selections and improvisations I also

provided opportunities as we sang for Danielle to “step out” with her voice and shine, but when I stopped playing and singing along with her from time to time, hoping she would sing on her own, she would feel unsupported and her voice would trail off. She needed to know I was holding her safely in the music so she could explore the sound of her voice.

Interviews

Interview data was transcribed soon after interviews were recorded and commonalities from the three interview sessions were noted. Cognitive and memory gains were seen outside the therapy sessions, as reported in interviews with Danielle’s care aide, Carmen (a certified nursing attendant or CNA), Danielle’s art therapist, Nancy, and her mother, Carolyn. Carmen, who had been working with Danielle for many years, related that she heard Danielle spontaneously singing the lyrics and the syntax of the melodies to newly introduced songs days after a music therapy session had taken place. She also reported that Danielle’s mood was elevated each week when she was reminded she was to meet with her music therapist as well as for some time after music therapy sessions. This was not always true of all of her therapy sessions. Danielle’s art therapist, Nancy, said in her interview that Danielle’s memory seemed improved after her introduction to music therapy, and that her affect and mood were more positive than before, adding a comment that “she’s more spontaneously happy now” (personal communication, February 18, 2012). Memory gains were also noted in art therapy sessions. Carolyn, Danielle’s mother, spoke of memories being triggered by the music played in the car while they were driving, and that Danielle seemed more cognitively aware since being introduced to music therapy.

Another positive change was seen in Danielle’s singing voice outside of music therapy. Carmen continued to reinforce her observations that Danielle was singing much more frequently

in many places throughout her day with none of her usual apologies for her vocal quality. Carolyn reported that Danielle began to sing out loud in church, something she had not been doing before her work in music therapy. In art therapy sessions, according to Nancy, Danielle was observed humming while working on art therapy projects and was more positive while participating. Able to let go of the critical self-judgment regarding her singing voice, she found joy in making her own sounds.

I am aware that, because I was still working with Danielle at the time this study was researched, the results of the interviews could be seen as biased. It was possible that interviewees could have held back or embellished some information because I was continuing to work with Danielle and would continue to be in contact with some of the team members on a weekly basis. However, in spite of the possibility of bias in the interview results, there was still substance in the reports made in the interview material. All three interviewees were seen separately and had not, to my knowledge, conferred with each other before the interviews were held. All three reported improvements in psychosocial behavior as well as in areas of musicality, memory, and cognition, results I had seen in our therapy sessions.

Countertransference

Bruscia (1998) defined the activation of countertransference in “environmental encounters” as having to do with “the various settings and contexts for therapy that may influence the therapist” (p. 68). In Danielle’s case, due to the frequent close proximity of care staff and family members during my sessions, my internal countertransference reactions were activated in the beginning. As Danielle and I began our work together I was conscious of my desire to be viewed as a good therapist, and wondered what the listeners might think as they heard our sounds through the closed door of our therapy space. When I understood my feelings

were connected to my experience of perfectionism within my family of origin, I was able to move them aside, trust in my work, and be more present in our sessions. Countertransference can be utilized to assist in the therapeutic work when the therapist is aware of the nature of her reactions and her “ability to use it to facilitate rather than obstruct the therapy process” (p. 68). My awareness of my tendency toward feelings of inadequacy when holding up unrealistic perfectionistic ideals continually reminded me to ask where my feelings were coming from and to remember and affirm my capabilities and strengths as a therapist (p. 86).

Carolyn, Danielle’s mother (a doctorate-level professor and research scholar herself), had given permission for me to study her daughter’s work in music therapy and knew that I was doing this project. She was also one of my interview subjects. As our music therapy sessions were conducted in the family home, I often had conversations with Carolyn as she came to say hello. I noticed my feelings of discomfort in my researcher role when she asked how my research paper was coming along, having just finished a session with her daughter in my role as therapist. I knew that she was understandably a fiery advocate for her daughter, and I often felt my self-inflicted pressure to give only positive replies. My high regard of her years of work in academia and in the research world also intimidated me at times at the beginning of this study when I felt unsure of myself as a neophyte researcher. Ely (1991) wrote that we can “influence the very phenomenon we are studying” in our dual roles (p. 47), and I tried my best to maintain healthy boundaries so that my work with Danielle would remain beneficial to her. A researcher-as-instrument must depend on her own self-examination and trustworthiness as she proceeds with the data analysis (p. 86). As the therapist and the researcher, I found myself conscious of the need to continue checking in with myself in order to keep my reporting trustworthy and as free of bias as possible. As much as I could, I kept my music therapy sessions separate from

my discussions with Danielle's mother about my research and discussed my countertransference reactions with a trusted mentor and psychotherapist outside the music therapy field.

What Does the Future Hold?

More community-based services are addressing the psychosocial and emotional needs of TBI survivors, moving the focus from acute-care-only concerns as persons with TBI return home and are incorporated into their communities (Nochi, 1998). While still needing full-time care, Danielle has been participating in TBI group sessions to work on social skills with other persons in recovery and to encourage further independence, and has a wide variety of stimulating creative, recreational, and therapeutic activities in her life. Her family is dedicated to making sure that she lives as full a life as possible. Trips to accompany her mother on academic lecturing commitments, vacations to visit family and friends, flights to the Caribbean where she swam with dolphins, and attendance at high school and college friends' weddings have been just a part of her reintegration into a world that holds a place for her.

Many of Danielle's character traits remained a part of her even after her injury, and along with her slightly wicked sense of humor, included a sense of adventure and willingness to try new things. She played the drum for the first time in music therapy, and joyfully participated with me in monthly community music drumming events at a park near her home during the summer. I noticed she was most engaged when there was a large crowd of drummers present and when the strong bass beat from a set of large African dunun drums anchored her own playing, creating safety for her with the supportive strength of the sound.

Danielle's future in music holds many possibilities. Pavlicevic (2006) described community-based music therapy programs that create potential for the creation of social networks. For Danielle, community music events can move her into the social world where she

can interact in a way that feeds her outgoing character. I see Danielle attending more interactive community music events and concerts with an increased attention span as the result of her expanded music awareness from her involvement in music therapy work. She told me she is now interested in writing poems and putting them to music, saying she wants to perform her work in front of audiences. Danielle is anxious to return to a life where she feels she is making a difference, and said, “I really believe my poems and songs could be an inspiration to other people with brain injuries.” Her life in recovery holds many opportunities to motivate others by sharing her experience through her creativity.

CONCLUDING THOUGHTS AND CLINICAL APPLICATIONS

Songs, whether pre-composed or improvised in therapy, act as a wonderful liaison between the present, past, and future; disability and the more able self; silence and sound. Turry (2006) wrote how song improvisation “provides a memorable tangible musical idea that can be remembered, returned to, and referred to” (p. 348). In Danielle’s case, collaborative songwriting was not only useful in creating memory tools, but also helped solidify our therapeutic relationship with shared music projects we brought back from week to week. The developing songs held special meaning for Danielle as a result of the creative process involved.

Expressing feelings through the act of singing “can lessen the sense of isolation with which clients often struggle” (Turry, 2006, p. 349). Magee (1999) wrote, “Through the sensitive and therapeutic use of song,” music therapists can provide support for clients’ “way of being in the world...[and] through mutual music making...facilitat[e] a new concept of wholeness...aiding in identity reconstitution” (p. 221). Songs in music therapy uncovered Danielle’s abilities in many areas, including lyric creation, vocalizing, and instrumental improvisation, and helped her connect with herself and others through songs. In spite of her

persistent declarations denigrating her musical abilities, Danielle proved to be intuitively and inherently rhythmic and wonderfully able in a variety of music-making processes employed in therapy. The therapeutic use of pre-composed and improvised songs in music therapy with Danielle helped her to continue building musical bridges between her past and her present identities, and creating exciting and enriching future possibilities for the music child that has always resided within her.

The implications for future work using pre-composed and improvised songwriting for music therapists in the area of TBI recovery are great. Even when music therapy is introduced years after an injury, positive change can be experienced as a result of these techniques. The interplay of words and music in familiar songs and song forms creates safety and solid ground for those in recovery from TBI who need to find their identity, recover and develop memory, and learn new coping skills. Even though some persons with TBI are unable to access verbal means of expressing feelings or thoughts, songs carefully chosen or improvised with the help of a music therapist can become their voice, saying what cannot be physically uttered and expressing that which has lain dormant--waiting for a song to awaken it and bring it to life.

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Appendix A

Sample Interview Questionnaire

1. What is your relationship to Danielle?
2. Describe how Danielle utilizes music in her daily activities?
3. Describe any situations, if any, in which you have noticed Danielle singing, humming, or mentioning songs outside of the music therapy sessions.
4. What was Danielle like before she began receiving music therapy?
5. Describe Danielle's musical expressions (aside from when she is in music therapy sessions) after her introduction to music therapy?
6. What role does music play in your own life?

Appendix B

Consent for Audio Recording of Interviews

Title of Study: I am Surrounded by Love: An Inquiry into the Use of Song with a Woman with Traumatic Brain Injury, 11 Years Post-Injury

Student Researcher:

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Thesis Committee Member:

Barbara L. Wheeler, Ph.D., MT-BC
Retired Professor, University of Louisville
Professor Emerita, Montclair State University
barbara.wheeler@louisville.edu

Dear _____,

You have been invited to participate in a study to learn more about the significance of the use of songs in music therapy in rehabilitation from traumatic brain injury. This study will be conducted by Pamela Carlton, a graduate student of music therapy at Molloy College, and is part of her degree and thesis requirements.

If you decide you wish to participate in this study, Pamela will need your consent to audio record your interview sessions and to use excerpts for educational purposes only. The recordings will not be shared outside of the research project.

Each interview session will last about 30 minutes, and will be held in a location convenient to you. Your participation is entirely voluntary, but you may decide during the study that you would like to stop participating in the study, at which time you may withdraw without any negative consequences.

This study is strictly confidential, and your name and any other identifying factors will not be used. Instead, pseudonyms will replace your real name in any written material. All digital recordings made during the interviews will be locked in a secure place when not being utilized. You have the right to listen to the recordings of your own sessions, and may request that the files be destroyed at any time.

No known risks to you exist in this study, other than those pertaining to your normal daily routine. Your participation in this study may help music therapists develop improved ways to work with other persons recovering from traumatic brain injuries.

Any questions you may have are welcome. You may phone Pamela at (516) 330-2858, or e-mail her at Musicpic@aol.com for more information or any problems that may arise for you during the study. You may also contact Dr. Suzanne Sorel at (516) 678-5000, X 6975 or at ssorel@molloy.edu. A signed copy of this consent form will be given to you for your records. Thank you for your participation.

Check all statements you agree to:

☐ I give permission to Pamela Carlton to audio record her interview sessions with me.

☐ I give permission to Pamela Carlton to use these recordings for educational purposes related to this research study.

Signing this form indicates agreement to the following:

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided at its conclusion upon my request. I know that I am free to withdraw from this study without negative consequence at any time. I understand I will receive a signed copy of this form.

Name _____

Signature _____ Date _____

Appendix C

Informed Consent for Audio Recording of Music Therapy Sessions

Title of Study: I am Surrounded by Love: An Inquiry into the Use of Song with a Woman with Traumatic Brain Injury, 11 Years Post-Injury

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Dear _____,

You have been invited to participate in a study to learn more about the significance of the use of songs in music therapy in rehabilitation from traumatic brain injury. This study will be conducted by Pamela Carlton, a graduate student of music therapy at Molloy College, and is part of her degree and thesis requirements.

If you decide you wish to participate in this study, Pamela will need to record your music therapy sessions and to use excerpts for research and educational purposes only. Excerpts may be used by the researcher to assist with musical analysis during research, and may also be used in educational presentations of the study.

Each weekly music therapy session lasts approximately one hour. Your participation is entirely voluntary, but should you decide during the study that you would like to stop participating in the study, you may withdraw without any negative consequences.

This study is strictly confidential, and your name and any other identifying factors will not be used. Instead, pseudonyms will replace your real name in any written material. All digital recordings made during the interviews will be locked in a secure place when not being utilized. You have the right to listen to the recordings of your own sessions, and may request that the files be destroyed at any time. Only the researcher and research committee will have access to the recordings.

No known risks to you exist in this study, other than those pertaining to your normal daily routine. Your participation in this study may help music therapists develop improved ways to work with other persons recovering from traumatic brain injuries.

Any questions you may have are welcome. You may phone Pamela at (516) 330-2858, or e-mail her at Musicpic@aol.com for more information or any problems that may arise for you during the study. You may also contact Dr. Suzanne Sorel at (516) 678-5000, X 6975 or at ssorel@molloy.edu. A signed copy of this consent form will be given to you for your records. Thank you for your participation.

Check all statements you agree to:

☐ I give permission to Pamela Carlton to audio record my music therapy sessions with her.

☐ I give permission to Pamela Carlton to use these recordings for educational purposes related to this research study.

Signing this form indicates agreement to the following:

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided at its conclusion upon my request. I know that I am free to withdraw from this study without negative consequence at any time. I understand I will receive a signed copy of this form.

Name of Guardian _____ Date _____

Signature of Guardian _____ Date _____